



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
September 26, 2024

Administrator  
Centracare Health System-Sauk Centre Nursing Home  
425 N Elm Street  
Sauk Centre, MN 56378

RE: CCN: 245341  
Cycle Start Date: September 18, 2024

Dear Administrator:

On September 18, 2024, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

#### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

## DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, RN, Regional Operations Supervisor

Marshall District Office

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

1400 East Lyon Street, Suite 102

Marshall, Minnesota 56258-2504

Email: [nicole.osterloh@state.mn.us](mailto:nicole.osterloh@state.mn.us)

Office: 507-476-4230

Mobile: (507) 251-6264 Mobile: (605) 881-6192

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

#### **FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY**

If substantial compliance with the regulations is not verified by December 18, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 18, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

#### **INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)**

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process  
Minnesota Department of Health  
Health Regulation Division  
P.O. Box 64900  
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: [https://mdhprovidercontent.web.health.state.mn.us/lrc\\_idr.cfm](https://mdhprovidercontent.web.health.state.mn.us/lrc_idr.cfm)

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

Centracare Health System-Sauk Centre Nursing Home

September 26, 2024

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Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a loop at the end of the last name.

Kamala Fiske-Downing

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245341</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/18/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>425 N ELM STREET</b> <b>SAUK CENTRE, MN 56378</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>On 9/13/24, 9/17/24, and 9/18/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed: H53418160C (MN106550) with a deficiency issued at F686.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	F 000		
F 686 SS=D	<p>Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to</p>	F 686		10/18/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>10/02/2024</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 686	<p>Continued From page 1</p> <p>promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to document assessments that occur during pressure ulcer dressing changes to include measurements and visual data and have a system to ensure appropriate reporting with findings and follow up occurred when the need for a more thorough assessment was identified for 1 of 1 resident (R1).</p> <p>Findings include:</p> <p>R1's admission Minimal Data Set (MDS) dated 8/20/24, indicated R1 had diagnoses of osteomyelitis of vertebra (infection in a bone), extradural and subdural abscess (area of pus located in brain), severe protein-calorie malnutrition, acute infarction of spinal cord (stroke within the spinal cord), and a pressure ulcer.</p> <p>R1's care plan dated 9/5/24, indicated R1 had a deep tissue pressure ulcer to coccyx. Staff were to administer pain medications as directed, observe for signs and symptoms of pain with treatments, ensure an air mattress was on his on bed, assist/encourage R1 to float his heels while in bed, ensure a foot cradle was in place to offload pressure, provide nutritional supplements as ordered, observe for signs or symptoms of infection, and reposition side to side every 2 hours. There was no mention staff were to document findings when providing ordered dressing changes.</p> <p>R1's Weekly Complex Wound Assessment dated</p>	F 686	<p>1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice.¿</p> <p>RN and Licensed Nurse complete wound vac change three times weekly with a progress note that describes the wound vac change, dressing change, and any change in the wound.</p> <p>RN completes weekly complex wound assessment which includes previous wound measurements, the amount of exudate, if odor is present, wound bed appearance, wound edges, surrounding skin, and tunneling or undermining, healing/deterioration of wound, current treatment, any change in treatment plan since last assessment, pain related to wound, and approximate percentage of each tissue type ex. slough, necrotic tissue, and granulation. Responsible party, provider, along with therapy and dietitian if applicable are notified for new or worsening complex wounds in a timely manner. Plan of care is then updated if necessary with changes regarding the wound.</p> <p>Resident sees WOC every 2 weeks and as needed if wound is noted to be deteriorating or per wound care order.</p>	

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F 686	<p>Continued From page 2</p> <p>8/14/24, identified R1 had an unstable pressure wound located on coccyx measuring 11 centimeters (cm) long, 2.7 cm wide, and depth was 0.3 cm. Further assessment identified moderate amount of serous (thin, watery, clear drainage) exudate, slight odor present, 10% granulation tissue (pink or red tissue with shiny, moist, granular appearance), 40% slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or mucinous), and 50% necrotic tissue (black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges). R1's wound was noted to have 0.3 millimeters (mm) tunneling at 6 o'clock. R1 was scheduled to have a wound consult on 8/22/24. R1's physician was notified.</p> <p>R1's Medication Administration Record (MAR) for August 2024, revealed R1 had a wound treatment order which was Mepilex 6x6 to coccyx ulcer three times a week and as needed if soiled. R1's Treatment Administration Record (TAR) identified dressing changes and wound treatments were completed on 8/16/24, 8/19/24, and 8/21/24.</p> <p>R1's progress notes identified no corresponding treatment note, originating for the TAR was made on 8/16/24, 8/19/24, or 8/21/24 that would identify characteristics of the pressure ulcer, changes that were identified by licensed staff, or notification for the need for a formal assessment due to changes in the wound. R1's medical record lacked evidence of a any wound assessment on 8/16/24, 8/19/24, or 8/21/24, when R1's wound treatment was completed.</p> <p>On 9/17/24 at 1:08 p.m., licensed practical nurse (LPN)-A stated as a licensed nurse if she was made aware there was a change with a resident's</p>	F 686	<p>2.How the facility will identify other residents having the potential to be affected by the same deficient practice.¿</p> <p>Facility will identify residents with wounds upon admission and identified assessments. Audit of all current residents with wounds was completed on 9/27/24.</p> <p>DON reviewed residents that currently have pressure ulcers and developed an audit from 9/27/24-10/18/24 that includes the following: All residents that have pressure areas or complicated wounds, dressing change completed, documentation completed, provider notification for new or worsening wounds,WOC consult needed, and any coaching that was needed. DON does an audit to ensure that the weekly RN complex wound assessment was completed with notifications to providers and responsible parties as applicable. This audit will be completed from 9/27/24-10/18/24. These audits will be reviewed at quarterly QAPI meetings. Audit to be completed by DON or designee.</p> <p>3.What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.¿</p> <p>For new admissions and those that are noted to be at risk interventions are being immediately implemented and the dietitian is consulted. Residents pressure risk and</p>	

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F 686	<p>Continued From page 3</p> <p>wound, she would complete an assessment and notify the director of nursing (DON) with the information as well as informing the resident's physician. LPN-A stated upon notifying management, they would complete a comprehensive assessment on the wound and assess the wound more thoroughly. LPN-A stated R1 was admitted to the facility with a sacral wound. LPN-A stated she observed R1's wound on Friday 8/16/24, and again on Sunday 8/18/24, and LPN-A stated the wound looked "worse" and notified registered nurse (RN)-A and DON via email. LPN-A was unsure "what happened after" that but assumed RN-A re-assessed R1's wound on Monday 8/19/24. In addition, LPN-A could not recall if she documented the wound in R1's medical record regarding identified changes she made during her observations while providing wound care.</p> <p>RN-A was no longer employed by the facility at the time of survey and was unavailable for interview.</p> <p>On 9/17/24 at 4:25 p.m., DON stated R1 was admitted to the facility with the wound on his coccyx. The DON was made aware the need for a formal assessment via email from LPN-A regarding a concern of R1's wound potentially worsening but could not recall what the email said specifically. It was addressed to RN-A and the DON had been cc' d on the email. DON stated there was no evidence in R1's record of R1's wound being re-assessed after the change was identified by LPN-A, nor was there documentation to support her visual assessments at the time dressing changes were performed had been documented. Staff were expected to re-assess a change in a wound, document the assessment,</p>	F 686	<p>care plan will be reviewed quarterly or sooner if any skin concerns arise, or resident has decline from baseline.</p> <p>Education was provided to nurses regarding charting and documentation, pressure ulcer/injury policy, and pressure ulcer/injury risk assessment policy, and a PowerPoint on the evaluation, documentation, and prevention of skin breakdowns such as pressure, incontinence associated dermatitis and cellulitis. Education due date is 10/8/24.</p> <p>Weekly education sessions with nursing team will start the week of 10/7/24 with various subjects presented during these sessions. Initial session and subsequent will be focused on skin integrity, prevention of pressure wounds, when to notify RN/provider on changes, and documentation for dressing changes. These sessions will evolve to include other subjects as needed.</p> <p>DON or designee will complete audits on wound/dressing change documentation and RN weekly complex wound assessments.</p> <p>Nursing department currently has a Performance Improvement Project related to documentation. This PIP includes audits of nursing documentation and coaching with staff.</p> <p>4.How the facility will monitor its corrective</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 686	<p>Continued From page 4 and add progress notes identifying changes or current status of wounds.</p> <p>Further interview on 9/17/24 at 5:07 p.m., with LPN-A identified she sent the email to RN-A and the DON on 8/18/24 at 4:34 p.m.. On 8/16/24, when she saw R1's wound the wound bed appeared to be red in color but on 8/18/24, the wound bed now appeared to have white slough in the wound bed and an area that appeared to be brown in color, and another area at the 5 p.m. mark (like on a clock) that appeared to show muscle involvement in the wound. In her opinion, the wound had appeared worse as she recalled that was a change from 8/16/24, when she observed it and provided the dressing change. LPN-A had not documented her finding from wound care or dressing changes to identify characteristics of the wound, in order for staff to determine if changes were occurring that would warrant a more formal assessment or the need to update the physician.</p> <p>On 8/18/24 at 10:04 a.m., family member (FM)-A stated R1 was admitted to the facility with the wound on his tailbone area. FM-A stated R1 was sent to the hospital on 8/21/24 for another concern, and the non-visible wound was debrided surgically, and a wound VAC (vacuum) was placed.</p> <p>On 8/18/24 at 12:26 p.m., the medical director (MD) stated he would expect the facility to follow policy and procedures and if needed, notify him if a wound had deteriorated or showed signs and symptoms of infection.</p> <p>On 8/18/24 at 1:00 p.m., DON confirmed there was no documentation to support that</p>	F 686	<p>actions to ensure that the deficient practice is being corrected and will not recur.</p> <p>DON or designee with complete 2-3 audits a week for the 4 weeks on dressing change documentation, wound change documentation, and notification of provider for deterioration of wounds. DON will continue the weekly RN complex wound assessment audit. DON or designee will continue coaching conversations and corrective actions with staff for any lack of documentation, wound follow up, and failure to notify provider. Residents pressure risk and care plan will be reviewed quarterly or sooner if any skin concerns arise, or resident has decline from baseline. These audits will be reviewed at next QAPI.</p> <p>5. The date that each deficiency will be corrected.¿</p> <p>10/18/24</p>	

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F 686	Continued From page 5 assessments were documented, or a more thorough assessment had been performed.  Review of facility policy titled Pressure Injury Management, dated April 2024, indicated a resident who had a pressure injury received necessary treatment and services to promote healing, prevent infection, and prevent the development of new pressure injuries. Upon performing dressing changes, staff were to have necessary supplies, practice good infection control technique, inspect the wound, noting location and color, amount, and odor of any drainage or necrotic (dead tissue) debris. Staff were to note these characteristics, measure the wound, notify the physician for signs of infection or wound deterioration, and document the procedure.	F 686		



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
September 26, 2024

Administrator  
Centracare Health System-Sauk Centre Nursing Home  
425 N Elm Street  
Sauk Centre, MN 56378

Re: State Nursing Home Licensing Orders  
Event ID: HMG111

Dear Administrator:

The above facility was surveyed on September 13, 2024 through September 18, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html). The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Osterloh, RN, Regional Operations Supervisor

Marshall District Office

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

1400 East Lyon Street, Suite 102

Marshall, Minnesota 56258-2504

Email: [nicole.osterloh@state.mn.us](mailto:nicole.osterloh@state.mn.us)

Office: 507-476-4230

Mobile: (507) 251-6264 Mobile: (605) 881-6192

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00640</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/18/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CENTRACARE HEALTH SYSTEM-SAUK CENTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>425 N ELM STREET SAUK CENTRE, MN 56378</b>
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS: On 9/13/24, 9/17/24, and 9/18/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE   	(X6) DATE  <b>10/02/24</b>
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2 000	<p>Continued From page 1</p> <p>have reviewed these orders and identify the date when they will be completed.</p> <p>The following complaint was reviewed. H53418160C (MN00106550) with a licensing order issued at 0900.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction.</p> <p>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html</a> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to</p>	2 000		

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2 000	Continued From page 2  the Minnesota  Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.  PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers  Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:  A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and  B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.  This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to document assessments that occur during pressure ulcer dressing changes to include measurements and visual data and have a	2 900	Corrected.	10/2/24

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2 900	<p>Continued From page 3</p> <p>system to ensure appropriate reporting with findings and follow up occurred when the need for a more thorough assessment was identified for 1 of 1 resident (R1).</p> <p>Findings include:</p> <p>R1's admission Minimal Data Set (MDS) dated 8/20/24, indicated R1 had diagnoses of osteomyelitis of vertebra (infection in a bone), extradural and subdural abscess (area of pus located in brain), severe protein-calorie malnutrition, acute infarction of spinal cord (stroke within the spinal cord), and a pressure ulcer.</p> <p>R1's care plan dated 9/5/24, indicated R1 had a deep tissue pressure ulcer to coccyx. Staff were to administer pain medications as directed, observe for signs and symptoms of pain with treatments, ensure an air mattress was on his on bed, assist/encourage R1 to float his heels while in bed, ensure a foot cradle was in place to offload pressure, provide nutritional supplements as ordered, observe for signs or symptoms of infection, and reposition side to side every 2 hours. There was no mention staff were to document findings when providing ordered dressing changes.</p> <p>R1's Weekly Complex Wound Assessment dated 8/14/24, identified R1 had an unstable pressure wound located on coccyx measuring 11 centimeters (cm) long, 2.7 cm wide, and depth was 0.3 cm. Further assessment identified moderate amount of serous (thin, watery, clear drainage) exudate, slight odor present, 10% granulation tissue (pink or red tissue with shiny, moist, granular appearance), 40% slough (yellow or white tissue that adheres to the ulcer bed in</p>	2 900		

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2 900	<p>Continued From page 4</p> <p>strings or thick clumps, or mucinous), and 50% necrotic tissue (black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges). R1's wound was noted to have 0.3 millimeters (mm) tunneling at 6 o'clock. R1 was scheduled to have a wound consult on 8/22/24. R1's physician was notified.</p> <p>R1's Medication Administration Record (MAR) for August 2024, revealed R1 had a wound treatment order which was Mepilex 6x6 to coccyx ulcer three times a week and as needed if soiled. R1's Treatment Administration Record (TAR) identified dressing changes and wound treatments were completed on 8/16/24, 8/19/24, and 8/21/24.</p> <p>R1's progress notes identified no corresponding treatment note, originating for the TAR was made on 8/16/24, 8/19/24, or 8/21/24 that would identify characteristics of the pressure ulcer, changes that were identified by licensed staff, or notification for the need for a formal assessment due to changes in the wound. R1's medical record lacked evidence of a any wound assessment on 8/16/24, 8/19/24, or 8/21/24, when R1's wound treatment was completed.</p> <p>On 9/17/24 at 1:08 p.m., licensed practical nurse (LPN)-A stated as a licensed nurse if she was made aware there was a change with a resident's wound, she would complete an assessment and notify the director of nursing (DON) with the information as well as informing the resident's physician. LPN-A stated upon notifying management, they would complete a comprehensive assessment on the wound and assess the wound more thoroughly. LPN-A stated R1 was admitted to the facility with a sacral wound. LPN-A stated she observed R1's wound on Friday 8/16/24, and again on Sunday 8/18/24,</p>	2 900		

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2 900	<p>Continued From page 5</p> <p>and LPN-A stated the wound looked "worse" and notified registered nurse (RN)-A and DON via email. LPN-A was unsure "what happened after" that but assumed RN-A re-assessed R1's wound on Monday 8/19/24. In addition, LPN-A could not recall if she documented the wound in R1's medical record regarding identified changes she made during her observations while providing wound care.</p> <p>RN-A was no longer employed by the facility at the time of survey and was unavailable for interview.</p> <p>On 9/17/24 at 4:25 p.m., DON stated R1 was admitted to the facility with the wound on his coccyx. The DON was made aware the need for a formal assessment via email from LPN-A regarding a concern of R1's wound potentially worsening but could not recall what the email said specifically. It was addressed to RN-A and the DON had been cc' d on the email. DON stated there was no evidence in R1's record of R1's wound being re-assessed after the change was identified by LPN-A, nor was there documentation to support her visual assessments at the time dressing changes were performed had been documented. Staff were expected to re-assess a change in a wound, document the assessment, and add progress notes identifying changes or current status of wounds.</p> <p>Further interview on 9/17/24 at 5:07 p.m., with LPN-A identified she sent the email to RN-A and the DON on 8/18/24 at 4:34 p.m.. On 8/16/24, when she saw R1's wound the wound bed appeared to be red in color but on 8/18/24, the wound bed now appeared to have white slough in the wound bed and an area that appeared to be brown in color, and another area at the 5 p.m.</p>	2 900		

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2 900	<p>Continued From page 6</p> <p>mark (like on a clock) that appeared to show muscle involvement in the wound. In her opinion, the wound had appeared worse as she recalled that was a change from 8/16/24, when she observed it and provided the dressing change. LPN-A had not documented her finding from wound care or dressing changes to identify characteristics of the wound, in order for staff to determine if changes were occurring that would warrant a more formal assessment or the need to update the physician.</p> <p>On 8/18/24 at 10:04 a.m., family member (FM)-A stated R1 was admitted to the facility with the wound on his tailbone area. FM-A stated R1 was sent to the hospital on 8/21/24 for another concern, and the non-visible wound was debrided surgically, and a wound VAC (vacuum) was placed.</p> <p>On 8/18/24 at 12:26 p.m., the medical director (MD) stated he would expect the facility to follow policy and procedures and if needed, notify him if a wound had deteriorated or showed signs and symptoms of infection.</p> <p>On 8/18/24 at 1:00 p.m., DON confirmed there was no documentation to support that assessments were documented, or a more thorough assessment had been performed.</p> <p>Review of facility policy titled Pressure Injury Management, dated April 2024, indicated a resident who had a pressure injury received necessary treatment and services to promote healing, prevent infection, and prevent the development of new pressure injuries. Upon performing dressing changes, staff were to have necessary supplies, practice good infection control technique, inspect the wound, noting location and</p>	2 900		

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2 900	<p>Continued From page 7</p> <p>color, amount, and odor of any drainage or necrotic (dead tissue) debris. Staff were to note these characteristics, measure the wound, notify the physician for signs of infection or wound deterioration, and document the procedure.</p> <p><b>SUGGESTED METHOD OF CORRECTION:</b> The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.</p> <p><b>TIME PERIOD FOR CORRECTION:</b> Twenty-one (21) days.</p>	2 900		